MEDEX 001

HEALTH DECLARATION AND CONSENT FORM

TO BE COMPLETED BY CANDIDATE/ EMPLOYEE

Full Name: (As in the I/C or Passport)	Staff/ IC/ Passport No:	Contact No: (mobile)		
Home Address/ Company Address:				
Place of examination: Date:	Birth Date: (dd/mm/yy)	Sex:	Male	☐
			Female	☐
Offered/ Current Job Title:				

DO YOU HAVE OR HAVE YOU HAD: (Tick 'YES' or 'NO')

		Y	N			Y	N			Y	N
1	Sinus problem			20	High blood pressure			39	Surgical operation		
2	Allergic rhinitis/ other allergy			21	Any blood disease			40	Accident/ Injury		
3	Any skin problem			22	Severe abdominal pain			41	Fear of heights		
4	Any ear discharge			23	Gastritis/ Ulcer			42	Fear in enclosed/ Confined space		
5	Neck/ gland swelling			24	Recurrent indigestion			43	Are you currently taking any medication?		
6	Dental problem			25	Jaundice/ Hepatitis/ Liver problem			44	Mental problem e.g. depression		
7	Severe headache/ Migraine			26	Gall bladder disease			45	Drugs and Alcohol problem		
8	Frequent dizziness/ Fainting episodes			27	Marked change in weight			**HAVE YOU EVER BEEN: -**			
9	Stroke			28	Marked change in bowel habits			46	Exposed to health hazards such as noise, dust, chemicals, heavy metals, radiation, etc.?		
10	Epilepsy			29	Kidney stone/ disease						
11	Lump in breast/ armpit			30	Painful passage of urine			47	Suffered from work related illness before such as asthma, skin condition, hearing loss, backache, blood disease, etc?		
12	Frequent lung infection			31	Blood in urine						
13	Shortness of breath			32	Piles/ Hernia						
14	Coughed/ Vomited blood			33	Blood in stools (motions)			48	Have you ever had any previous abnormal audiometry/ lung function test/ Chest x-ray?		
15	Bronchial asthma/ bronchitis			34	Varicose veins						
16	Tuberculosis			35	Serious joints/ Spinal problem			49	**HAVE YOU HAD OTHER ILLNESS(S)**		
17	Serious chest pain			36	Gout			**FOR WOMEN ONLY – Have you ever had: -**			
18	Abnormal heartbeat			37	Diabetes			50	Any gynaecological problem?		
19	Heart disease			38	Cancer			51	Are you pregnant?		

Do you smoke/ vape? Yes/ No	Do you take alcohol regularly? Yes/ No If yes, amount per week?

Have any of your family members suffered from the following?

☐Diabetes	☐High blood pressure	☐Tuberculosis	☐Heart disease	☐Stroke
☐Blood disease	☐Cancer	☐Bronchial asthma	☐Eczema	☐Epilepsy

MEDEX 001

DECLARATION & CONSENT STATEMENT

I, the undersigned, declare and certify that the disclosure of the above information has been made voluntarily and that the information given above is true and complete to the best of my knowledge. I understand that false declaration of any information required above may result in disciplinary action and/or legal proceedings being taken against me.

For Fitness to Work health assessment including pre-employment, I hereby give consent to the examining Medical Examiner to disclose the information given in this MEDEX Forms and the result of my health assessment to the Company Health Advisors and/or authorized PRefChem Personnel for the purposes of management of all matters related to PRefChem employment processes.

For Preventive Health assessment (screening), I understand that medical data will be analysed anonymously for the purpose of the PRefChem health and wellness program implementation. My personal identity will not be revealed at any point of analysis nor will be used for Fitness to Work or employment processes.

I understand that PRefChem shall endeavour to implement the appropriate security safeguards and administrative procedures in accordance with the applicable local laws and regulations to prevent unauthorized or unlawful processing, usage and accidental loss or destruction of/ or damage to, my Personal Data.

I have read, understood and accept the contents of this Consent Statement given herein and I hereby give my consent for PRefChem to manage my Personal Data in the PRefChem Occupational Health Database System.

Name:_____ Signature:_____ Date:_____

(Employee)

Questionnaire reviewed by:

Name:_____ Signature:_____ Date:_____

(AME/ Medical Examiner)

MEDEX 002

HEALTH ASSESSMENT

Employee Name | Staff/ NRIC/ Passport No.

N = Normal, A = Abnormal, NA = Not Applicable

		N	A	NA			N	A	NA
1	Eyes				8	Skin			
2	Ear, Nose & Throat				9	Varicose Veins			
3	Oral/ Teeth				10	Extremities/ Musculoskeletal			
4	Lungs/ Chest				11	Neurological			
5	Cardiovascular				12	Genitourinary			
6	Abdomen				13	Breast			
7	Hernia Orifices				14	Anus & Rectal Examination			

Assessments & Examinations Finding/Medical Remarks

CLINICAL AND LABORATORY TEST RESULTS

		N	A	NA			N	A	NA
1	Audiometry				7	Serum Electrolytes			
2	Chest X-Ray				8	Serum Lipids			
3	ECG				9	Urea & Creatinine			
4	Lung Function Test				10	Liver Function Test			
5	Full Blood Count				11	Liver Function Test			
6	Fasting Blood Glucose				12	Urine Drug Test			

Total Chol (mmol/L) | Fasting Blood Glucose (mmol/L) | Blood Grp | Stress Test | PAP Smear | Mammogram

Audiometry Test Results (RIGHT) Left blank if there's no value

Frequency (KHz)	0.5	1.0	2.0	3.0	4.0	6.0	8.0	Avg 0.5,1,2	Avg. 0.5,1,2,3	Avg. 2,3,4
dB										

Audiometry Test Results (LEFT) Left blank if there's no value

Frequency (KHz)	0.5	1.0	2.0	3.0	4.0	6.0	8.0	Avg 0.5,1,2	Avg. 0.5,1,2,3	Avg. 2,3,4
dB										

Assessments & Examinations Finding/Medical Remarks

If yes / applicable, kindly select (X) relevant box (confirmed diagnosis only)

☐Diabetes Mellitus ☐Hypertension ☐Ischaemic Heart Disease ☐Bronchial Asthma ☐Smoking / Vaping

Prepared by :

PENGERANG REFINING COMPANY SDN. BHD. (201301028727 (1058557-T))
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+(607) 878 7777 contactus@prefchem.com www.prefchem.com

MEDEX 003

FITNESS TO WORK CERTIFICATE

Employee Name		Staff/ NRIC/ Passport No.	

This is to certify that I have examined the above named person and found his/her fitness status as follows:

ASSESSMENT TYPE		RESULT *Fit / Unfit / Fit with Restriction*	NEXT DUE *Validity/Expiry Date of the assessment (dd.mm.yyyy)*
☐ Pre-employment			
☐ Pre-Placement			
☐ Exit			
☐ PHS – Periodic (Preventive)			
☐ For-Cause			
☐ Return to Work			
☐ Job Specific			

Restriction Info:		
	☐ Job	
	☐ Duration	
	☐ Location	
	Restriction End Date *(dd.mm.yyyy)*	

Remarks To HR (For Unfit/FWR cases, kindly state the risk and implication if the candidate/staff is allowed to work)

Medical Advice / Consultation To Employee

Date *(dd.mm.yyyy)*

.....

AME'S/Medical Examiner Signature

AME's/Medical Examiner Name :

Clinic Name :

AME'S stamp

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